

EXHIBT 9

650-1S-12 (6/91) (3/01)

I certify that I have examined Edward Neal Thompson in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- | | |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> wearing corrective lenses | <input type="checkbox"/> driving within an exempt intracity zone (49 CFR 391.62) |
| <input type="checkbox"/> wearing hearing aid | <input type="checkbox"/> accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> accompanied by a _____ waiver/exemption | <input type="checkbox"/> qualified by operation of 49 CFR 391.64 |

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER <u>Barbara Elliott</u>	TELEPHONE (812) 263-2013	DATE 04/26/05
MEDICAL EXAMINER'S NAME (PRINT) <u>Barbara Elliott</u>	MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Physician Assistant <input checked="" type="checkbox"/> Advanced Practice Nurse	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO./ISSUING STATE <u>71000103</u> INDIANA	DRIVER'S LICENSE NO. <u>4657210</u> STATE <u>IN</u>	
SIGNATURE OF DRIVER <u>Edward Neal Thompson</u>	ADDRESS OF DRIVER <u>801 5th Ave Geneva IL 60340</u>	
MEDICAL CERTIFICATE EXPIRATION DATE <u>04/26/05</u>		

DISTRIBUTION: 1 COPY TO THE DRIVER, 1 COPY TO THE MOTOR CARRIER